STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

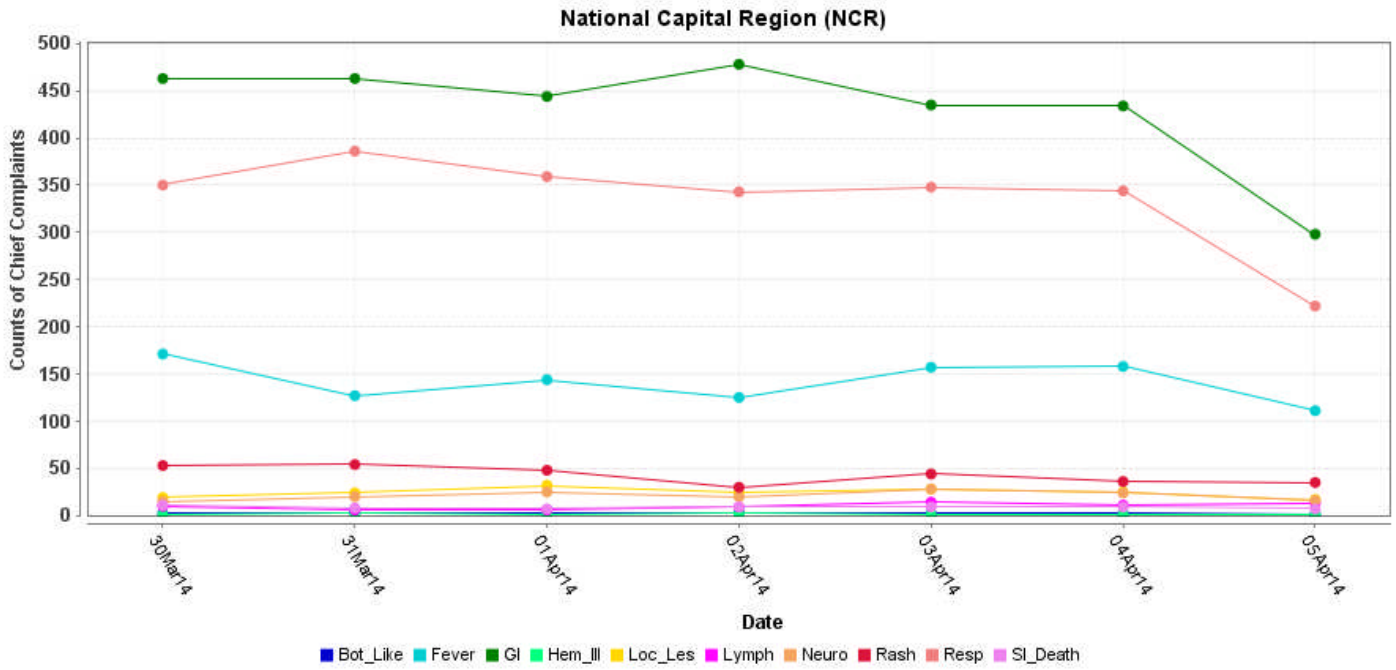
April 11, 2014

Public Health & Emergency Preparedness Bulletin: # 2014:114
Reporting for the week ending 04/05/14 (MMWR Week #114)

CURRENT HOMELAND SECURITY THREAT LEVELS

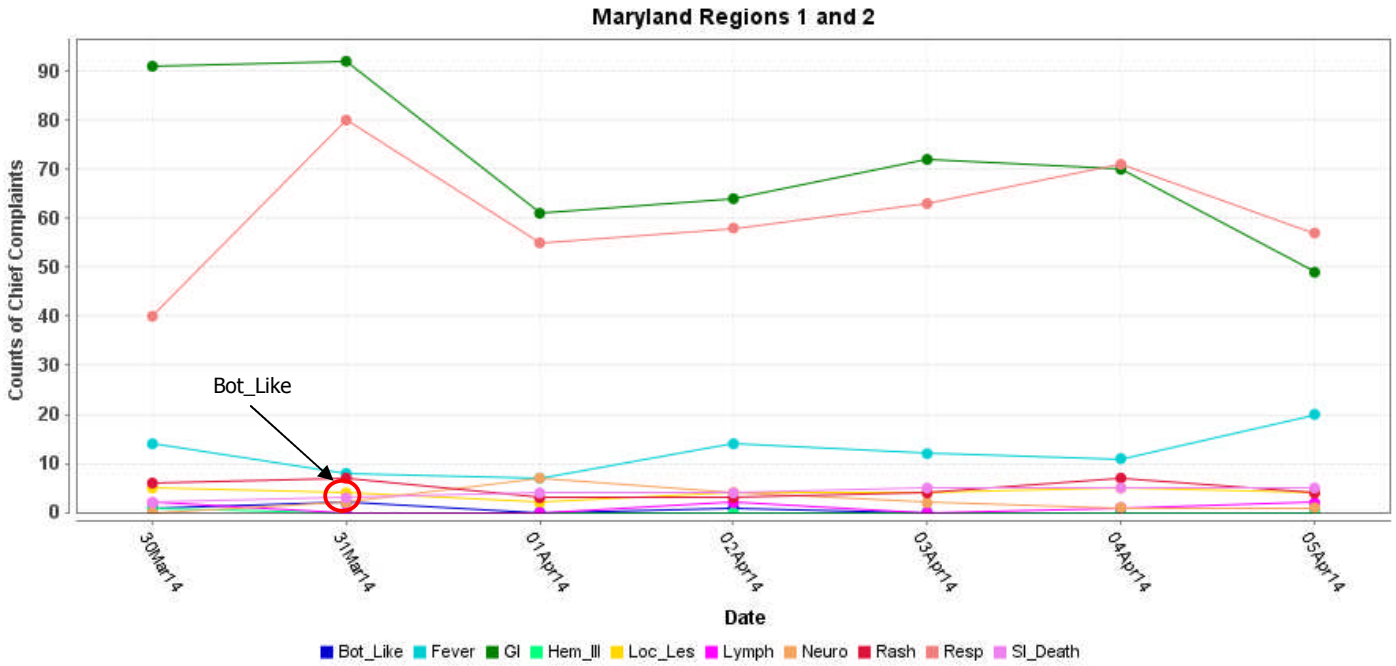
National: **No Active Alerts**
Maryland: **Level Four (MEMA status)**

SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.
Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

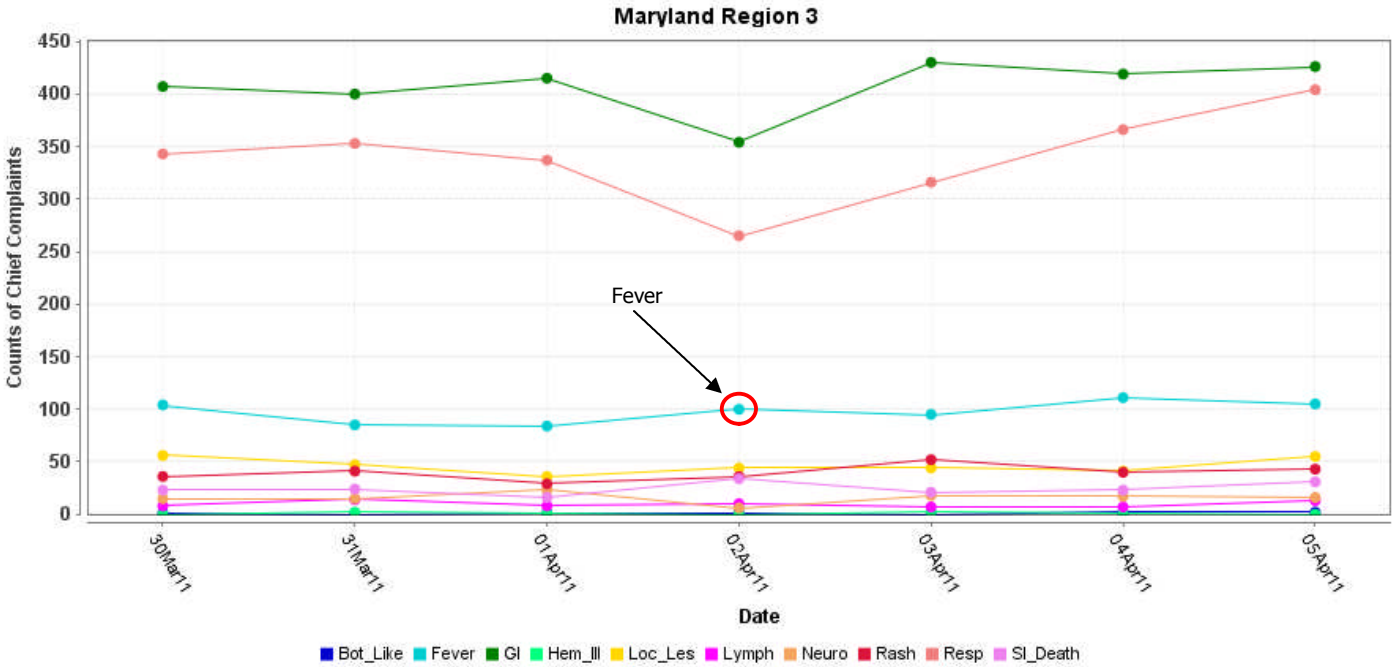


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

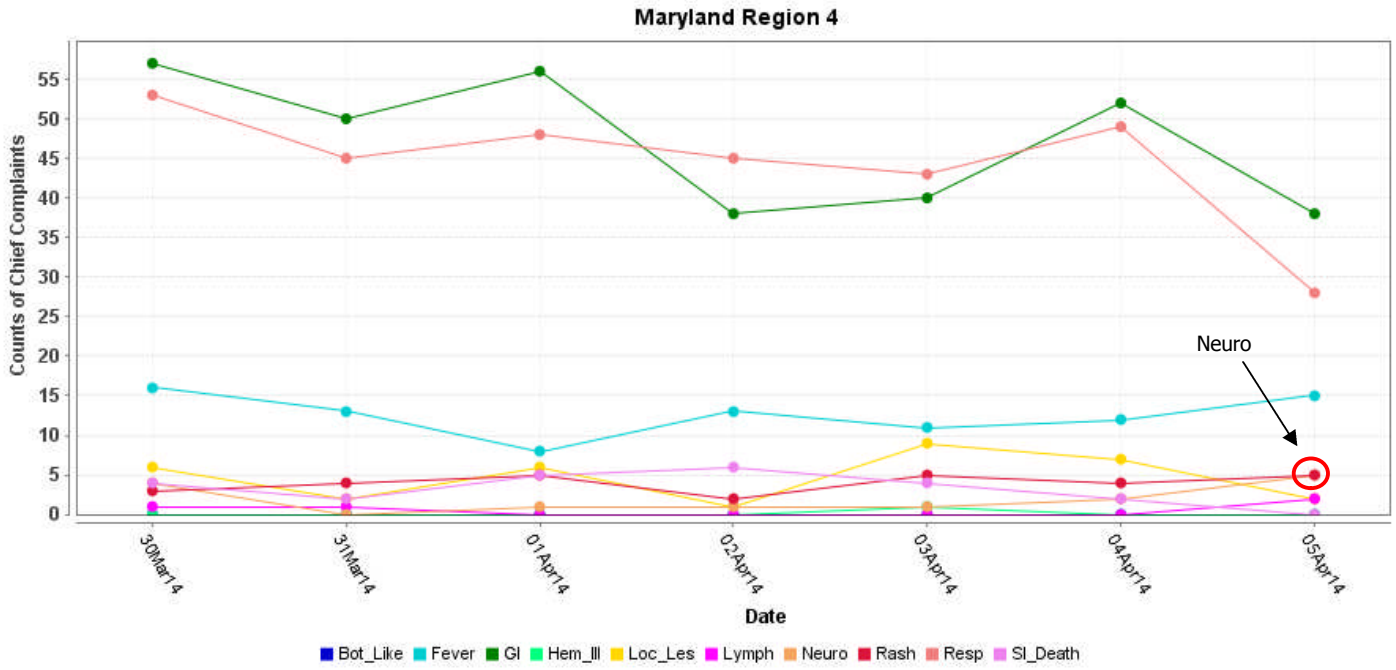
MARYLAND ESSENCE:



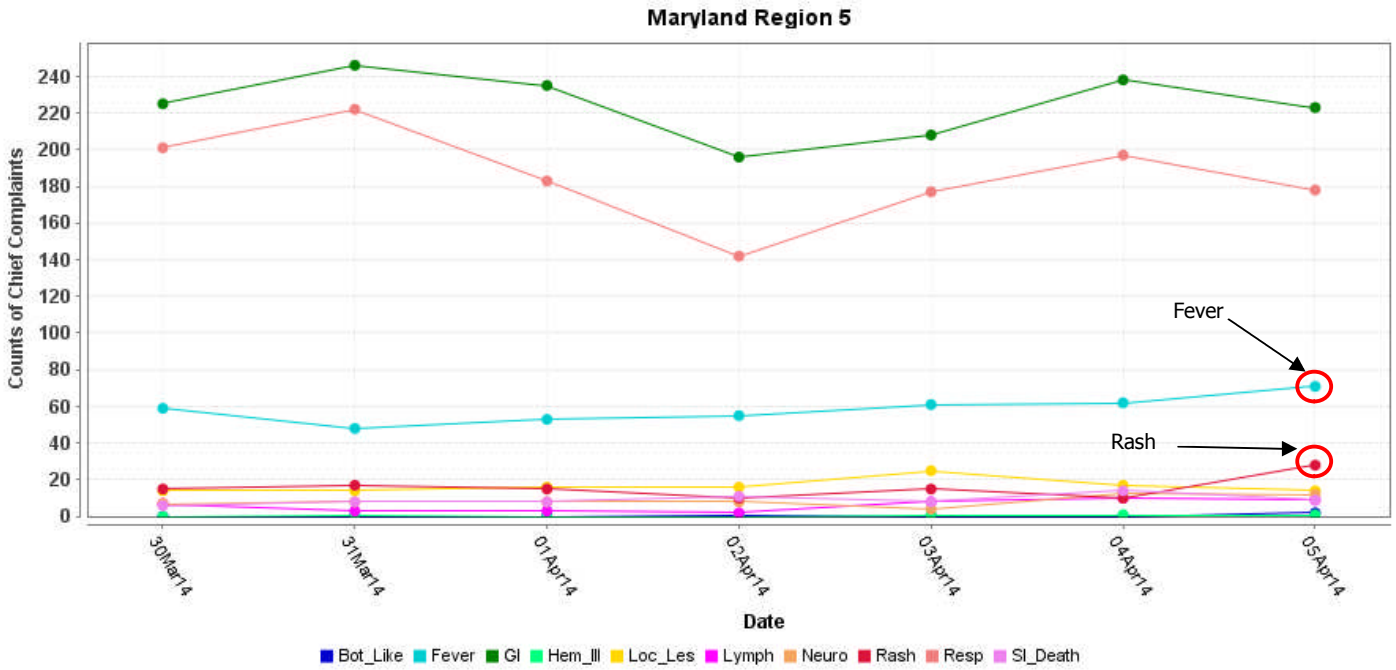
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



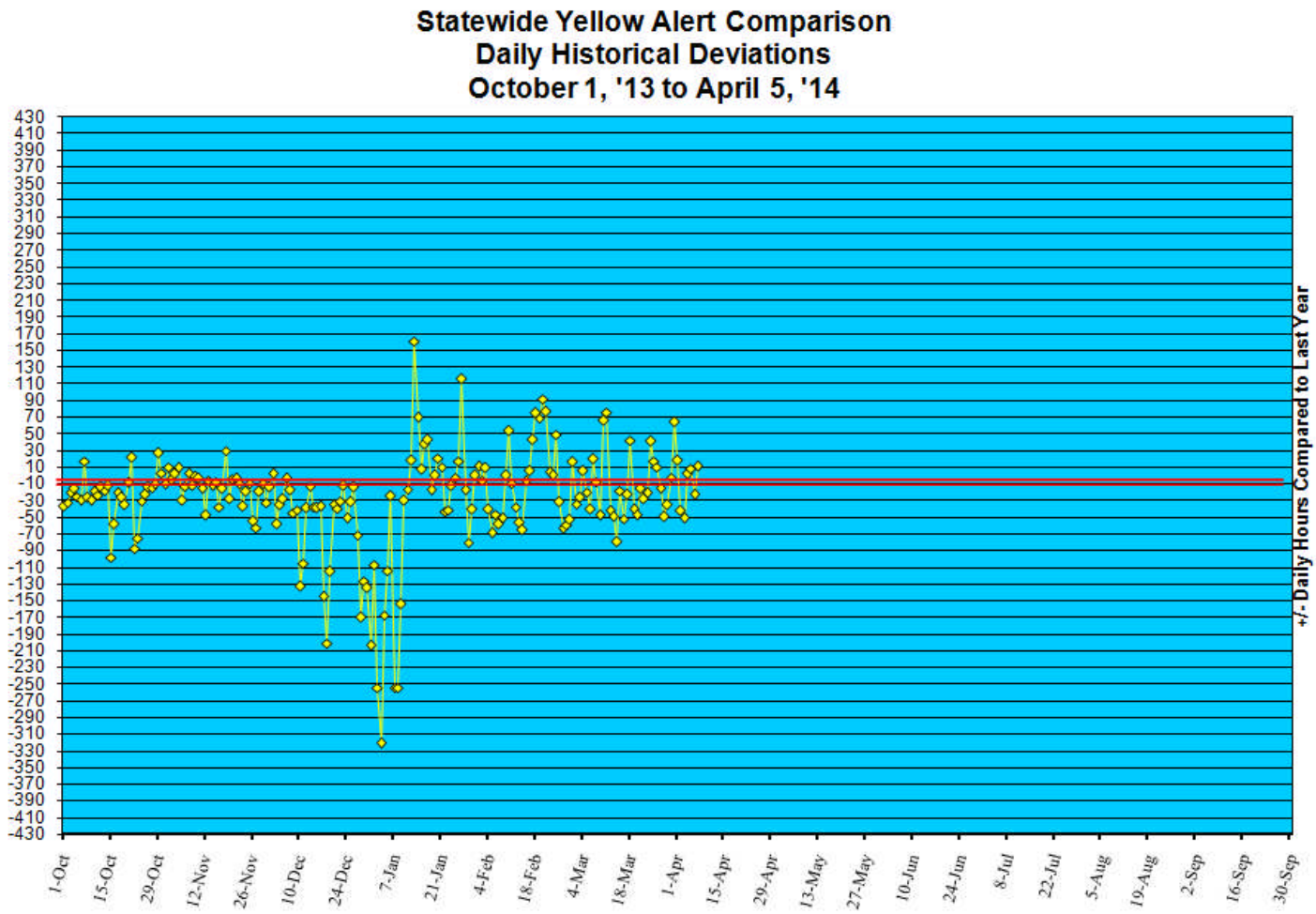
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/13.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in February 2014 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (March 30 - April 5, 2014):	7	0
Prior week (March 23 - March 29, 2014):	11	0
Week#14, 2013 (March 31 - April 6, 2014):	8	0

6 outbreaks were reported to DHMH during MMWR Week 14 (March 30 - April 5, 2014)

5 Gastroenteritis Outbreaks
2 outbreaks of GASTROENTERITIS in Nursing Homes
3 outbreaks of GASTROENTERITIS in Assisted Living Facilities

1 Respiratory Illness Outbreak
1 outbreak of INFLUENZA in an Assisted Living Facility

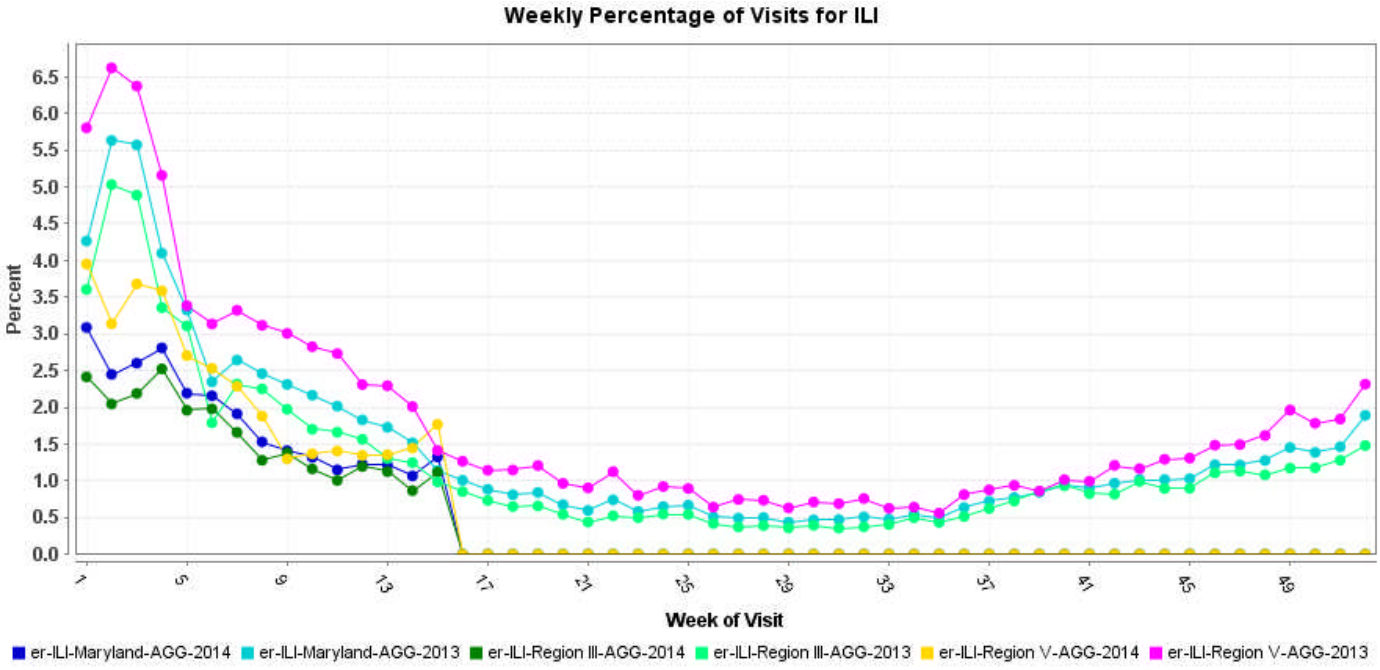
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May. Seasonal influenza activity for Week 14 was: Local with Minimal Intensity.

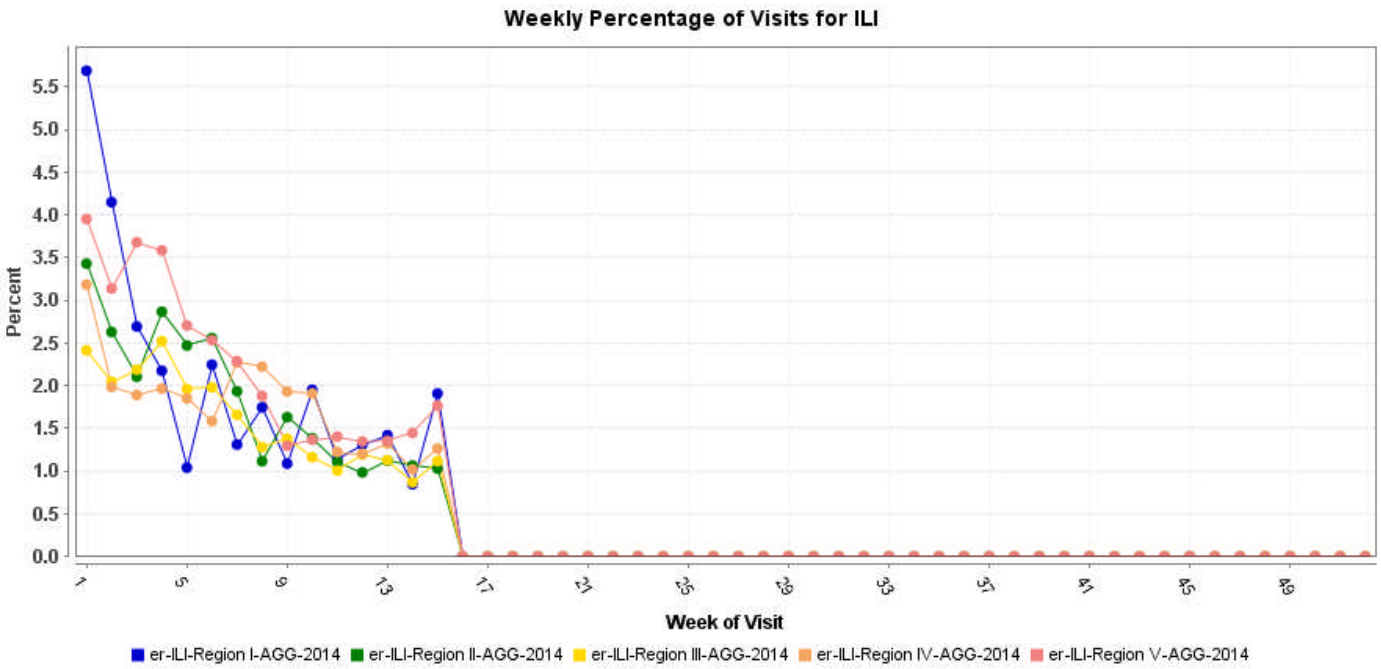
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



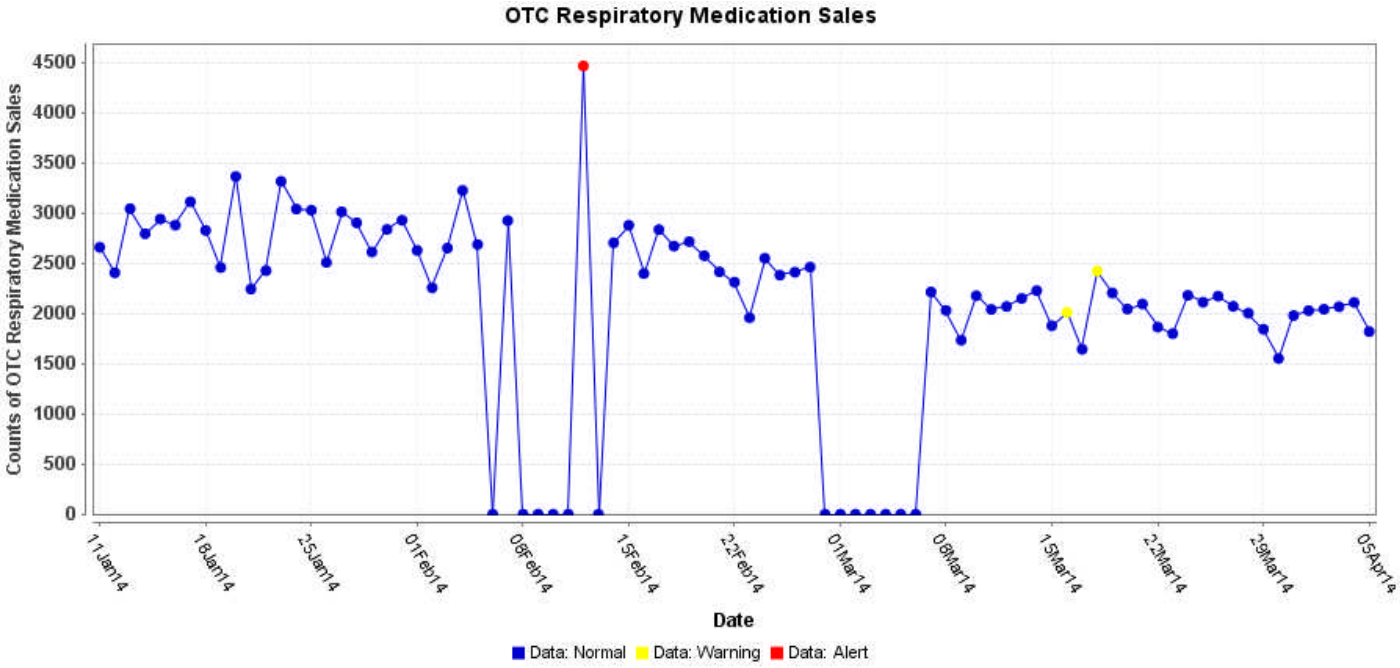
* Includes 2013 and 2014 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2014 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of January 24, 2014, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 650, of which 386 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

AVIAN INFLUENZA (H7N9): On [31 Mar 2014], the National Health and Family Planning Commission (NHFPC) of China notified WHO of 3 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus.

Details of the cases reported to WHO are as follows:
- A 35-year-old man from Wuxi City, Jiangsu Province. He became ill on [17 Mar 2014] and was admitted to hospital on [24 Mar 2014]. He is currently in a critical condition.
- A 72-year-old man from Fuzhou City, Fujian Province. He became ill on [23 Mar 2014] and was admitted to hospital on [27 Mar 2014]. He is currently in a severe condition. The patient has a history of exposure to poultry.
- A 65-year-old man from Shaoyang City, Hunan Province. He became ill on [21 Mar 2014] and was admitted to hospital on [29 Mar 2014]. He is currently in a severe condition. The patient has a history of exposure to poultry.

The Chinese government has taken the following surveillance and control measures:
- strengthen surveillance and situation analysis;
- reinforce case management and treatment; and
- conduct risk communication with the public and release information.

Current risk assessment
The overall risk assessment has not changed (see WHO Risk Assessment under "Related links"). The previous report of avian influenza A(H7N9) virus detection in live poultry exported from mainland China to Hong Kong SAR shows the potential for the virus to spread through movement of live poultry; at this time, there is no indication that international spread of avian influenza A(H7N9) has occurred. However, as the virus infection does not cause signs of disease in poultry, continued surveillance is needed. Further sporadic human cases of avian influenza A(H7N9) infection are expected in affected and possibly neighboring areas. Should human cases from affected areas travel internationally, their infection may be detected in another country during or after arrival. If this were to occur, community level spread is unlikely, as the virus does not have the ability to transmit easily among humans. Until the virus adapts itself for efficient human-to-human transmission, the risk of ongoing international spread of H7N9 virus by travelers is low. WHO advises that travelers to countries with known outbreaks of avian influenza should avoid poultry farms, or contact with animals in live bird markets, or entering areas where poultry may be slaughtered, or contact with any surfaces that appear to be contaminated with feces from poultry or other animals. Travelers should also wash their hands often with soap and water. Travelers should follow good food safety and good food hygiene practices. WHO does not advise special screening at points of entry with regard to this event nor does it currently recommend any travel or trade restrictions. As always, a diagnosis of infection with an avian influenza virus should be considered in individuals who develop severe acute respiratory symptoms while travelling or soon after returning from an area where avian influenza is a concern. WHO encourages countries to continue strengthening influenza surveillance, including surveillance for severe acute respiratory infections (SARI), and to carefully review any unusual patterns in order to ensure reporting of human infections under the IHR (2005) and continue national health preparedness actions.

NATIONAL DISEASE REPORTS*

LASSA FEVER (USA): 4 April 2014, The CDC and the Minnesota Department of Health (MDH) have confirmed a diagnosis of Lassa fever in a person returning to the United States from West Africa. The patient was admitted to a hospital in Minnesota on [31 Mar 2014] with symptoms of fever and confusion. Blood samples submitted to CDC tested positive for Lassa fever on [3 Apr 2014]. The patient is recovering and is in stable condition. "This imported case is a reminder that we are all connected by international travel. A disease anywhere can appear anywhere else in the world within hours," said CDC Director Tom Frieden, M.D., M.P.H. Lassa fever is a severe viral disease that is common in West Africa but rarely seen in the United States. A total of 7 other Lassa fever cases, all travel related, have been identified in the United States, with the last one reported in Pennsylvania in 2010. Although Lassa fever can produce hemorrhagic symptoms in infected persons, the disease is not related to Ebola hemorrhagic fever, which is responsible for the current outbreak in West Africa. In West Africa, Lassa virus is carried by rodents and transmitted to humans through contact with urine or droppings of infected rodents. In rare cases it can be transmitted from person to person through direct contact with a sick person's blood or bodily fluids, through mucous membrane, or through sexual contact. The virus is not transmitted through casual contact. About 100 000 to 300 000 cases of Lassa fever, and 5000 deaths related to Lassa fever, occur in West Africa each year. CDC is working with public health officials and airlines to determine the patient's travel route from West Africa and identify any passengers or others who may have had close contact with the infected person. Preliminary information indicates that the patient flew from West Africa to New York City and caught another flight to Minneapolis. "Given what we know about how Lassa virus is spread to people, the risk to other travelers and members of the public is extremely low," said Martin Cetron, M.D., M.P.H., director of CDC's Division of Global Migration and Quarantine. "Casual contact is not a risk factor for getting Lassa fever," said Barbara Knust, D.V.M., M.P.H., an epidemiologist in CDC's Division of High-Consequence Pathogens and Pathology, which performed the laboratory testing. "People will not get this infection

just because they were on the same airplane or in the same airport." As part of its investigation, CDC is working with the airlines to gather contact information for passengers and crew who were seated near the infected individual. CDC will provide passenger contact information to state and local health departments where the passengers live to notify them about their possible exposure. For additional information about Lassa fever, see the CDC website at http://www.cdc.gov/vhf/lassa/. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents)

E. COLI (OKLAHOMA): 3 April 2014, Several Oklahoma families have been hospitalized with *E. coli* illnesses after attending the same event at the State Fairgrounds [in Oklahoma City, Oklahoma County]. While some cases are minor, some are more severe, putting one 8-year-old in ICU. [The boy] is on dialysis, has received several blood transfusions and is breathing with the help of a ventilator. His mother had a minor case that put her in the hospital for just a few days. But they aren't the only ones. A cousin says the boy is surrounded by several families at the hospital with the same illness, who all attended the same youth expo. "We just kind of want some answers to know where it came from," she said. "That way it can be stopped." The state health department's Lauri Smithee says the possibilities are endless. "At this time we are not able to definitively say we have a contaminated this or that, or stall or barn or food vendor," says Smithee. "These particular organisms are really only found in the intestinal tract of ruminant animals, which are cows, sheep, goats and perhaps deer." It could also be found in contaminated foods. So they're investigating everything from the livestock to the food trucks. The health department urges anyone who has attended events on the State Fairgrounds since the Oklahoma Youth Expo to not ignore any flu-like symptoms, like vomiting and diarrhea without a fever. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents)

INTERNATIONAL DISEASE REPORTS*

BOTULISM (CANADA):4 April 2014, A Korean-made rice product is being recalled because of concerns it may allow the growth of a bacterium that causes botulism. The Canadian Food Inspection Agency [CFIA] says Rice Porridge with Abalone from Korea Food Trading Ltd. is sold in Ontario and New Brunswick but may also have been distributed in other provinces. The product is sold in a round 288-gram container featuring Korean characters with a code reading 2015-01-24. The federal health agency says anyone who has the product should throw it out or return it to the store where it was purchased. Food contaminated with the toxin (*Clostridium botulinum*) may not look or smell spoiled but can still make you sick. The CFIA says symptoms can include nausea, vomiting, fatigue, dizziness, blurred or double vision, dry mouth, respiratory failure and paralysis. In severe cases of illness, people may die. There have been no reported illnesses associated with the consumption of this product. (Botulism is listed in Category A on the CDC List of Critical Biological Agents)

SALMONELLOSIS (UNITED KINGDOM): 3 April 2014, Five new cases of salmonella with possible links to laverbread have emerged in the past week [approx. 27 Mar to 3 Apr 2014], bringing the total number to 17, said Public Health Wales. Tests are continuing to confirm whether they are all linked to the outbreak, which has 9 confirmed cases so far. Cases have been reported across south and west Wales. A total of 3 people have needed hospital treatment, but have been discharged. Health officials said a study has confirmed a strong association with laverbread from Penclawdd Shellfish Processing Ltd, probably produced and distributed between 5 and 8 Mar 2014. Last week, the company voluntarily withdrew its laverbread from sale as a precaution. Samples taken from its Swansea factory have not shown any evidence of salmonellae in either food or in the environment, said Public Health Wales. Dr Jorg Hoffman, consultant in communicable disease control, said: "Public Health Wales, the Food Standards Agency and environmental health officers from 5 councils are investigating an outbreak of salmonella that has now affected up to 17 people." He added that laverbread was generally a safe product to eat, and it remained unclear whether it was the source of this outbreak. Cases of salmonella have so far been identified in Swansea, Neath Port Talbot, Carmarthenshire, Rhondda Cynon Taf and the Vale of Glamorgan. Laverbread is the boiled and minced laver seaweed, often fried with bacon and cockles as a traditional Welsh breakfast dish. The seaweed is eaten worldwide, especially in Asia, and is often used in Japanese sushi dishes. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents)

BOTULISM (TAJIKISTAN): 1 April 2014, A 10-year-old boy died in the Asht central district hospital on 31 Mar 2014 of botulism poisoning. The boy was one of 33 residents of the Qahramon village in Sughd [Sogd]'s Asht district who have contracted botulism poisoning by eating home-canned tomatoes. According to the Sughd Center for Sanitary and Epidemiological Supervision, 4 of them were in the intensive care unit. "On 21 Mar 2014, some 95 residents of the village of Qahramon gathered to celebrate the Navrouz holiday, and 33 of them contracted botulism poisoning by eating home-canned tomatoes," said the source. "On 23 Mar 2014, they were taken to the Asht central district hospital, where they were treated for botulism." Botulism is a rare and potentially fatal paralytic illness caused by a toxin produced by the bacterium *Clostridium botulinum*. The disease begins with weakness, trouble seeing, feeling tired, and trouble speaking. This may then be followed by weakness of the arms, chest muscles and legs. The disease does not usually affect consciousness or cause a fever. Botulism can occur in a few different ways. The bacterial spores that cause it are common in both soil and water. They produce botulinum toxin when exposed to low oxygen levels and certain temperatures. Foodborne botulism happens when foods containing the toxin are eaten. Foodborne botulism results from contaminated food in which *C. botulinum* spores have been allowed to germinate in low oxygen conditions. This typically occurs in home-canned food substances and fermented uncooked dishes. Given that multiple people often consume food from the same source, it is common for more than a single person to be affected simultaneously. Symptoms usually appear 12-36 hours after eating, but can also appear within 2 hours to 10 days. (Botulism is listed in Category A on the CDC List of Critical Biological Agents)

EBOLA VIRUS (WEST AFRICA): 1 April 2014, In this update and subsequent ones, the terminology Ebola haemorrhagic fever will be replaced by Ebola virus disease (EVD) in line with the International Classification of Diseases (ICD-10). Therefore, this report provides an update on Ebola virus disease (EVD) in Guinea, Liberia and Sierra Leone. As at 31 Mar 2014, the Ministry of Health of Guinea has reported 122 clinically compatible cases of EVD, of which 24 are laboratory confirmed by PCR, and 98 are probable (78) or suspected (22) cases. This total number includes 80 deaths, of which 13 (16 percent) have been laboratory confirmed for EVD and the remaining 67 are considered as probable cases of EVD. These figures correspond to 19 new clinical cases and 14 new deaths since 28 Mar 2014. As of 30 Mar 2014, 20 patients remain in isolation. A total of 11 health care workers are among the probable and suspected cases. Cases have been reported from Conakry (11), Guekedou (77), Macenta (23), Kissidougou (8), and 3 from Dabola and Djingaraye combined. Case investigation and contact tracing are continuing, with 400 contacts under medical follow-up at present. Further strengthening of infection prevention and control in health care facilities is a priority intervention. In addition, efforts are continuing to raise awareness in the community about the importance of personal protective measures to prevent ebolavirus transmission including hand washing, caring for the sick safely in the community, the use of personal protective equipment when handling potentially contaminated blood and body fluids and during environmental cleaning and disinfection, and safe burials. The Ministry of Health of Liberia has reported 8 clinically compatible cases of EVD, including 2 laboratory-confirmed cases, from 14 to 30 Mar 2014. The 2 confirmed cases were reported from Lofa County. Two patients died; one of the deceased patients has been laboratory confirmed and the other death was in a probable case. Contact tracing is underway. Response activities in Liberia include a press conference by the Ministries of Health and Social Welfare and Ministry of Information, distribution of EVD prevention and control guidelines to health care workers, training staff on case detection, contact tracing and follow up, clinical case management, infection prevention and control, specimen collection handling

and transportation and the safe handling of deceased patients. Staff from the Ministry of Health and Social Welfare and WHO have travelled to Lofa County to provide technical support and coordinate control efforts. Clinical specimens from suspected cases are being sent to the laboratory in Conakry, Guinea, for testing. Intensive community awareness raising campaigns are also underway through the mass media, via social mobilization activities and interpersonal communications, and involvement of telephone service providers in sending text messages. The Ministry of Health of Sierra Leone is maintaining a high level of vigilance following the deaths of 2 probable cases of EVD in one family who died in Guinea and their bodies repatriated to Sierra Leone. To date [1 Apr 2014], active surveillance activities have identified no new suspected cases and all contacts of the deceased have remained well. As this is a rapidly changing situation, the number of reported cases and deaths, contacts under medical observation and the number of laboratory results are subject to change due to enhanced surveillance and contact tracing activities, ongoing laboratory investigations and consolidation of case, contact and laboratory data. WHO does not recommend that any travel or trade restrictions be applied to Guinea, Liberia or Sierra Leone based on the current information available for this event. The risk of infection for travellers is very low since most human infections result from direct contact with the body fluids or secretions of infected patients, particularly in hospitals (nosocomial transmission) and as a result of unsafe procedures, use of contaminated medical devices (including needles and syringes) and unprotected exposure to contaminated body fluids. Travellers should avoid all contact with infected patients. Those who are providing medical care or are involved in the evaluation of an outbreak should wear protective clothing, including masks, gloves, gowns, and eye protection, and practice proper infection prevention and control and measures. Anyone who has stayed in the areas where EVD cases have been recently reported should be aware of the symptoms of infection and seek medical attention at the 1st sign of illness. Clinicians managing returning travellers from visiting these areas with compatible symptoms are advised to take into consideration the possibility of EVD. Malaria, typhoid fever, shigellosis, cholera, leptospirosis, plague, rickettsiosis, relapsing fever, meningitis, hepatitis and other viral haemorrhagic fevers are differential diagnoses to consider in these patients. Further guidance on travel health risks and prevention can be found at WHO's International Travel and Health website (http://www.who.int/ith/en/). (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents)

National and International Disease Reports are retrieved from http://www.promedmail.org/.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/ or follow us on Facebook at www.facebook.com/MarylandOPR.

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

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Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumococcal meningitis, viral encephalitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephalitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable